unlikely, and I marshalled some supporting statistics. If it ever becomes common, I expect it will result not only from an increased number of female physicians but from some radical changes in societal attitudes, such as destruction of the "double standard", which is, unhappily, alive and well.

I can't agree that even the initial stages of physician–patient acting-out are unambiguously gratifying. Women in this situation suffer fear and feelings of powerlessness.

I am intrigued by Seeman's statement that "women . . . tend to view ethical problems as personal choices rather than as moral obligations". Men do this as well.[1] Of course, there may be reasons more compelling than ethics for ignoring stock-market tips proffered by patients.

My nit-picking here should not obscure the important lessons to be learned from Seeman's letter, which is much appreciated.

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Statement on influenza vaccination for the 1987–88 season

I was interested to note in this statement (*Can Med Assoc J* 1987; 137: 223–225), from the National Advisory Committee on Immunization, the comment that "since 1976 no association of Guillain–Barré syndrome with influenza vaccination has been observed". On Oct. 16, 1986, I reported to the Drug Adverse Reaction Programme, to the Health Protection Branch of the Department of National Health and Welfare and to the manufacturer of the vaccine the development of profound Guillain–Barré syndrome in a 48-year-old woman 22 days after vaccination with a 1986–87 influenza vaccine of Canadian origin. Although it was clearly not possible to demonstrate a cause-and-effect relationship, there were no other plausible etiologic factors.

I think it is inaccurate and misleading to tell Canadian physicians that there has been no observed association between influenza vaccination and Guillain–Barré syndrome since 1976, and I wonder if any other reports have been similarly disregarded.

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[Dr. Stanley E. Acres, secretary of the National Advisory Committee on Immunization, replies:]

In 1976 a temporal association was noted between administration of A/New Jersey/76 (swine) influenza vaccine and Guillain–Barré syndrome, the latter occurring within 10 weeks after vaccination. In the United States the incidence rate of the syndrome among vaccinated adults was approximately 10 cases per million, five to six times higher than the rate reported for unvaccinated adults. In Canada 16 cases occurred in 1.11 million vaccinees, compared with 30 in the unvaccinated 9 million ($p < 0.01$).

Canadian hospital morbidity statistics since 1971 show a remarkably constant incidence rate of Guillain–Barré syndrome, about 600 cases annually. Although sporadic cases temporally associated with influenza vaccination (such as that reported by Dr. Martin) have been reported in Canada since 1976, we have no data to demonstrate any statistically significant excess risk of the syndrome after influenza vaccination.

Experience in both countries suggests that the complications documented after the administration of swine influenza vaccine in 1976 were unique. Subsequent vaccines, which have been prepared from other virus strains, do not appear to be associated with an increased frequency of Guillain–Barré syndrome.

It was the intent of the National Advisory Committee on Immunization to reassure physicians that no statistically significant association has been demonstrated. Nevertheless, I will ensure that Martin's comments are brought to the committee's attention so that the wording of subsequent statements is changed.

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Advances in the Management of Chronic Pain

We are disappointed that Dr. Gordon M. Wyant chose to overlook the positive aspects of our book *Advances in the Management of Chronic Pain* in his review (*Can Med Assoc J* 1987; 137: 138–139).

The majority of the papers in our book discuss the treatment of severe pain due to cancer. Accordingly, it is appropriate that morphine, the analgesic of choice for severe cancer pain, received considerably greater recognition than alternative analgesics. Obviously our book would have been more comprehensive had it included greater information on the nature of pain, pain assessment, coanalgesics and nondrug therapy. However, it was neither intended as, nor does it purport to be, a stand-alone treatise on pain management. It does present considerable information on the pharmacokinetics and pharmacodynamics of both parenteral and oral morphine, an understanding of which is necessary for optimal use of the drug.

We realize that Dr. Wyant may find little novel information in reports of studies demonstrat-

ing that oral morphine, either in solution or as sustained-release tablets, can be highly effective in controlling severe cancer pain and that it does not result in addiction, euphoria or rapid tolerance. However, that fact does not detract from the importance of the information to those who do not use the drug effectively because of misconceptions about its safety or efficacy in those vulnerable patients.

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Drug legislation in the silly season

I disagree with the reasoning of David Woods (*Can Med Assoc J* 1987; 137: 271) and the drug companies in support of Bill C-22 and agree with the Liberal senators in their actions. I have heard the doctors and the pharmaceutical industry, together with senators from the United States, arguing strongly on behalf of the bill. However, nowhere have I seen a full analysis of the number of jobs to be created, amount of money to be spent and potential benefits to the Canadian public in comparison with the current risks.

If history is to be a teacher, we should learn that drugs are usually developed and initially tested in Europe and eastern Asia, not in the United States or Canada. Therefore, I see little rationale to the argument that we will be doing original research by virtue of this bill. We will simply be doing manufacturing. We will remain forever at the mercy of market forces rather than developing a stable, research-based industry.

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Propylthiouracil and breast-feeding

Dr. A.W. Myres, correcting a statement in the guide *Feeding Babies*,[1] says that propylthiouracil should not be used by nursing mothers (*Can Med Assoc J* 1987; 136: 921). However, recent studies have shown that small doses of this drug can be safely used during nursing.[2-6]

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[Dr. Myres replies:]

Dr. Goldman and others have drawn attention to current data indicating that propylthiouracil can be safely used by nursing mothers. Although those data suggest that this drug is not concentrated in human milk to the degree suspected from earlier studies — and these data were known to us at the time of writing — there are several reasons for retaining the current statement in *Feeding Babies*.

First, propylthiouracil is listed as contraindicated for nursing mothers in the 1987 edition of the *Compendium of Pharmaceuticals and Specialties*, published by the Canadian Pharmaceutical Association. The Department of National Health and Welfare has not received any data from the drug manufacturer proving that the drug when transmitted via breast milk would not harm the nursing infant. This may seem an overly bureaucratic response, yet it illustrates an important point of principle; namely, that according to the Food and Drugs Act and Regulations the onus for the provision of proof of safety rests with the drug manufacturer.

Second, *Feeding Babies* is a federal publication intended to provide national guidelines for health professionals. Thus, it should not be regarded as a rigid standard but, rather, as a set of general guidelines to be used with the understanding that specific advice should always be in-